UTAH MEDICAID NURSING FACILITY
State Fiscal Year 2014
QUALITY IMPROVEMENT INCENTIVE (2)(vii) APPLICATION
Clinical Software and Hardware, Rule R414-504-4

This form and all supporting documentation must be postmarked or faxed on or before May 31, 2014

Facility Name: _____

Medicaid Provider I.D. _____ Administrator: _____

Please mark all that are complete:

☐ This facility purchased or leased new or enhanced existing clinical information systems software, which incorporates advanced technology into improved patient care including better integration, capture of more information at the point of care, more automated reminders etc.

☐ The following clinical tracking minimum requirements are all included in the software:
- Care Plans;
- Current conditions;
- Medical orders;
- Activities of Daily Living;
- Medication Administration Records;
- Timing of medications;
- Medical notes; and
- Point of care data tracking.

☐ This facility purchased or leased new or enhanced existing clinical information systems hardware. The hardware facilitates the tracking of patient care and integrates the collection of data into clinical information systems software that meets all the tracking criteria above.

☐ A detailed description of the clinical information systems software and/or hardware is attached.

☐ The clinical information systems software and/or hardware was paid for by May 31, 2014.

☐ The clinical information systems software and/or hardware was installed between July 1, 2012 and May 31, 2014.

☐ Proof of purchase that includes receipts and invoices, is also attached. This includes proof of payment, i.e. cancelled check(s), financial debt instrument, etc.

Qualifying facilities may receive up to $580.18 per Medicaid Certified bed for any combination of purchase for clinical information systems software and hardware (counts as at 7/1/2013) under this incentive.
This incentive is part of incentive (2). The maximum a facility may receive from all incentives in incentive (2) combined, is $580.18 per Medicaid Certified bed (count as at 7/1/2013).
Facilities will not receive more than was expended under this incentive.

Attach Spreadsheet for detail expenditures
Total Reimbursement Requested (should match spreadsheet): $_____

Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.
By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____

Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify. Fax to: 801-323-1595 <or> Mail instructions: http://health.utah.gov/medicaid/stplan/longtermcare.htm

For Medicaid use only:		
Amount reimbursed:	Maximum per-bed payout:	Date Paid